DEPARTMENT OF MEDICAID SERVICES

BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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Meeting held via Zoom Videoconferencing

September 9, 2020,
commencing at 1 p.m.

A T T E N D A N C E

Committee Members:

Sheila Schuster, Ph.D., Chair

Steve Shannon
Sarah Kidder
Valerie Mudd
Alan Brenzel
Kathy Dobbins
Gayle DiCesare

DR. SCHUSTER: This the Behavioral Health Technical Advisory Committee. I'm Sheila Schuster, the Chair of the BH TAC, and I'm going to ask our voting members of the TAC to introduce themselves. Gayle.

MS. DICESARE: Gayle DiCesare representing BIAK.

DR. SCHUSTER: Great. Thank you. Sarah Kidder.

MS. KIDDER: Sarah Kidder representing NamiKY.

DR. SCHUSTER: Wonderful. Thank you. Valerie Mudd.

MS. MUDD: Valerie Mudd with the Consumer Voice.

DR. SCHUSTER: Wonderful. And Steve Shannon.

MR. SHANNON: Steve Shannon with KARP Association and other mental health centers.

DR. SCHUSTER: Wonderful. Thank you. And I'm Sheila Schuster representing the Kentucky Mental Health Coalition.

Well, our six voting TAC members who could not be here, Mike Barry who represents

People Advocating Recovery. That's the substance abuse disorder advocacy group.

Commissioner Lee, could you introduce yourself and then have folks in DMS introduce themselves, please?

COMMISSIONER LEE: Hello. I am Lisa Lee. I am the commissioner for the Department for Medicaid Services, and I would ask that those members from DMS introduce themselves. I can see a few, but I can't see all, but I see Ms. Hoffman, if you would like to introduce yourself?

MS. HOFFMAN: Hello, I'm Leslie Hoffman, and I just returned back from the Cabinet, and I'm so happy to be back, and I assist with the Behavioral Health Initiatives.

COMMISSIONER LEE: Dr. Judy Theriot.

DR. THERIOT: Hi. This is a Judy Theriot. I'm medical director.

DR. SCHUSTER: Great. We're delighted to have you. We haven't had you join our meeting before, Dr. Theriot. Thank you.

COMMISSIONER LEE: Ann Hollen.

MS. HOLLEN: Hey, everyone. This is Ann Hollen, behavioral health policy advisor within the Cabinet, Department for Medicaid Services.

DR. SCHUSTER: Great. Thank you.

COMMISSIONER LEE: And I think that's all. If I missed anybody, feel free to raise your hand or introduce yourself, if you're from Medicaid.

MS. HOLLEN: Commissioner Lee, I think some of our other behavioral health team members are on, so it's Angela Sparrow, Leigh Ann, or Sherry, want to introduce yourselves?

MS. SHERRY: Sorry. Sherry Staley, behavioral health specialist.

MS. SPARROW: Angela Sparrow, behavioral health specialist. It's good to see everyone's faces.

MS. FITZPATRICK: Hi. Good afternoon. Leigh Ann Fitzpatrick with -- behavioral health specialist with Department for Medicaid.

MS. PARKER: Angie Parker with

Medicaid. I'm on here, too, but I am also double duty, so...

DR. SCHUSTER: Great. Thank you so much.

MS. HUGHES: Dr. Brenzel.

DR. SCHUSTER: Yeah, I was going to say, from DBH DID, Department of Behavioral Health Developmental Intellectual Disabilities. Dr. Brenzel?

DR. BRENZEL: Hi. Alan Brenzel, as mentioned, director of Behavioral Health. Glad to be here.

THE COURT: Great. Is anybody else on, do you know, Alan, from DBH?

DR. BRENZEL: I do not.

DR. SCHUSTER: Is there anybody else on from the Department of Behavioral Health?

DR. BRENZEL: I do not see anybody.

DR. SCHUSTER: All right. Well, thank you, again, so much.

We have the minutes, were sent out to you. Think back on March 11th when we were actually there in person in the Annex. If you remember, they had just started

rearranging chairs in the committee meeting rooms to keep people socially distanced, and that was one of the last meetings probably that was held in the Annex. So I have attached for you all the minutes. I was actually reviewing them this morning, and there is a typo on the second page, the fourth line. It says, Another provider working with you, Y-O-U, and it should be youth, Y-O-U-T-H, noted the problem, etc., etc. So they need to be approved with that correction. Do I have a motion from one of our voting TAC members?

MR. SHANNON: I'll vote. Steve Shannon.

MS. MUDD: Second.

DR. SCHUSTER: All right. Any additions, corrections, omissions, revisions? All right. All those in favor of approving the minutes with that correction signify by saying aye.

MOTION CARRIES

DR. SCHUSTER: Thank you very much. And our big topic of the day as it was back in March, I'm going to turn over to you,

Commissioner Lee, to follow up on the targeted case management issues, particularly after the state of emergency ends. So if you could give us an update at this point with what's going on, what you're seeing, and what you're thinking about going forward, that would be fabulous.

COMMISSIONER LEE: Thank you. Glad to be here to talk about the important topic. Currently, we have asked all managed care organizations to not have any prior authorizations on any services related to the treatment of substance abuse disorders or behavioral health. And after our conversation, I've gone back and I started digging into a little bit of history just to try to find out what's going on with targeted case management. In large, targeted case management was a topic out of discussion years ago in CMS and section 605 2 of the deficit reduction act actually reformed case management, targeted case management. So what we want to do going forward is definitely make these services available to all individuals that need targeted case

management, and we want to make sure that services are being delivered properly. So I have not had a chance -- I'm not sure that our Medicaid state plan amendment which was effective June the 19th of 2014 which was shortly after we expanded Medicaid is in compliance with that, and then we have several Medicaid regulations.

So basically our state plan on discussing targeted case management, we have specific groups. We have groups -- we have targeted case management for individuals who -- for substance disorder. We also have targeted case management pharmacies for individuals for mental health or substance use disorder and chronic...health, and also have targeted case management for populations with a severe mental illness and children with a severe emotional disability.

And the first thing we want to do is definitely make sure these individuals receive those service and that they align with our regulations.

I can send out to this group a copy of the Medicaid state plan specific to targeted

case management as outlined, Medicaid services, and of course the regulations are on-line. I can send you that.

But the other thing I did, Dr. Schuster, I went in and I pulled some reports because I think that what this -- what this TAC is charged with is to make sure that services are being delivered to our individuals and to try and look and see what's going on. And if I can, try to share my screen and show you a little bit of a draft report that we've pulled -- I say this is draft, because this is the first iteration of it. And let me see if I can share. It says host has disabled me from sharing my screen.

DR. SCHUSTER: Sharley, can you make the commissioner a host to share her screen?

MS. HUGHES: Let me see if I can figure out how to do that.

COMMISSIONER LEE: I've received a message that I am a host. So let's see if I can share my screen. Behavioral TAC targeted case management. Do you see all that? Here is a -- just a graph. This is just real --

start out simple so we know what we need to see.

So these -- we had -- we ran a report based on our encounter claims data from our managed care organizations, so this is all aggregate information. So what we're showing here back in July of 2018, they were serving, the blue line is those individuals under age 18, and the green is individuals over the age of 18. So what we see back in about July of 2018, there were just a little bit under 8,000 individuals. Looks like it kind of remains steady, but there was a dip here in July of 2019. And then here, February '20, we expected this dip here because this is when Covid-19 was declared a health emergency.

So now we have this spike here. We see that it's going out for over 18. So the MCOs are providing more targeted case management to individuals over 18 right now. Again, we believe that's probably due to the prior authorization being lifted. So you can see that graph. We enrolled more individuals in the program, too.

The children under 18 seems to be kind of steady. We saw that dip a little bit. So that's what we're seeing in MCO.

This is the MCO targeted case management payments, so you can see that the red is for under 18 and the purple is over 18. So that kind of follows the graph a little bit that we saw before.

So now here is the Medicaid fee for service. I don't know what's going on here, but it looks like here in February we saw this big decline in targeted case management. And, again, this area here is the Covid period, so we expect to see that. But if we go back here to February of '19, we kind of see a decrease. This is under 18, and the green line is over 18. We're seeing in the fee for service compilation a little bit of a decrease in targeted case management, I think more so than in the fee for service. That, to me, looks a little odd, and that's why I said this was draft information, but I wanted you all to see what we're seeing here.

This is payments in a fee for service, and as you can see here in April of '19,

don't know what's happening, but as you're seeing a decline here in services, it seems to me that we've got an increase in payment. So that's something we probably need to dig into a little bit more and kind of start looking at what may have happened and what more, maybe, the children -- the number of children seem to decline. So we need to confirm that information.

Again, I wanted to get this out there to you just so you could start looking and thinking about what specific information do we need to look at to ensure that individuals are receiving targeted case management appropriately and what kind of trends do we want to see along with what we're hearing out in the community.

So I'm going to -- and I can keep these up for a minute if anybody has any questions. I'll stop there.

DR. SCHUSTER: Thank you, Commissioner. Does anybody have any questions about the slides to ask the Commissioner? You can put your name in the chat, or since nobody is weighing in, I guess

I have a question. I want to be sure that I'm interpreting -- so if you look at the difference, Commissioner, between slide 4, which is the members served which seems to be, you know, kind of on a slope down, although the -- is the top line the over 18 or under 18?

COMMISSIONER LEE: The blue, the top line, is the under 18.

DR. SCHUSTER: Under 18. Okay. So it's a little bit unsteady but trending down. And then if you go to slide 5, what you're saying is you've got those things, but here we've got lots more payments than it looks like we had people served?

COMMISSIONER LEE: Yeah, the number of people were slightly going down in April of '19, and then if you look at payments, they went up. So definitely something I think we would want to look at.

DR. SCHUSTER: And this, of course, is in the fee for service or the waiver programs, right?

COMMISSIONER LEE: This is in the waiver programs, anything fee for services.

The MCO kind of seems steady. We did see that dip there in June and July of '19, and it had to do with our population, so I think that's another thing we need to look at is what did the Medicaid enrollment numbers look like? Did we see a corresponding dip there? We did see the increase here during the Covid.

DR. SCHUSTER: That's also when the prior authorization was lifted, right, was lifted at what point in March or April?

COMMISSIONER LEE: I think it actually implemented in March because I think that February we started talking about Covid, but we didn't actually start making a lot of changes until March. This is where the prior authorization was limited.

DR. SCHUSTER: Right. All right. Anyone else have any questions of the commissioner about these lines?

MR. SHANNON: Yeah, Sheila. This is Steve Shannon. I just want to understand, so we're seeing members served in payment. You know, is there a lag between those two things?

COMMISSIONER LEE: We pulled the data based on pay dates, I believe. So, you know, there's a couple of different ways you can pull data in Medicaid. You could either do data service or pay date. Usually, the providers are pretty good about getting their claims turned in. I'm not sure there'd be much of a difference, you know, another way.

DR. SCHUSTER: Good question, Steve. Anybody else have any questions of the commissioner? Because I guess the piece that's the unknown here, Commissioner, is what is the outcome of the case management, right?

COMMISSIONER LEE: Right, right.

DR. SCHUSTER: And do we have a way of getting at that because that's been -- that's been discussed, as you know, at the BH TAC meeting in March when you were there. It was also discussed in January, some of the MCOs feeling like case management didn't necessarily keep people out of the hospital, you know, any providers feeling like it does. So I don't know how we could have that, but that would seem to be a really important

piece of the puzzle here.

COMMISSIONER LEE: And how do we gain effectiveness in targeted case management? What are some areas or some things that we need to look at that we have access to in our claims data? We can definitely look at, like you said Dr. Schuster, we could go back and we could get this same time period and we could identify those individuals who have targeted case management and see what their ER utilization was, but then what do we compare that to? And I think those are some of the hardest questions this TAC is, you know, charged with answering and moving forward to see what is effective. Is targeted case management working? Do we need to have other interventions? Is it working better in one county than it is in another county, those sorts of things.

So I think going forward, we're definitely not -- not keen on changing a lot of the targeted case management, things that are, for example, prior authorizations. We're not real keen on putting that prior

authorization back in until we can get some of this information to show is it effective, is it not, and we're going to have to work as a team with the MCOs and behavioral health and this TAC to figure out what information we need to look at to see if targeted case management is effective. I see Dr. Brenzel has raised his hand, so I will --

DR. SCHUSTER: Great. Go for it, Dr. Brenzel.

DR. BRENZEL: I was just going to say, you know, the concerns have been around what appears to us to be an underutilization of case management and some other of the lower end services. And initial obstacles, having no pre-auth is really important and we're very incredibly all very grateful for that. But that doesn't mean that they're not doing concurrent reviews or retrospective reviews. We were hearing stories about denials based on the fact that the person received no other services, therefore there was nothing to case manage. And some of those were the homeless outreach folks that were going out and reaching people and trying

to engage them in services and, yet, at the point they were getting case management they were not in services, but the goal was to get them into healthcare -- and so, you know, it'd be worth looking at denied claims at retrospective reviews and reasons for denials of ongoing because what we were hearing is they're authorizing a month, but then they're not reviewing the authorization. And I'd hope that that's not occurring, but I'd be anxious to be hear from providers who are in this audience or on a committee about what they're experiencing with targeted case management.

COMMISSIONER LEE: And I think that, with targeted case management, too, to your point, Dr. Brenzel, going back in and looking at, for example, the deficit reduction that CMS came up with. You know, they defined case management as consisting of services... access needed to medical, social education and other services. So it is possible that somebody would have case management but not targeted, but they define targeted case management as services that are

aimed specifically at special groups. So targeted case management, have to figure out what the difference between targeted case management, but I think it's just population.

DR. BRENZEL: Yeah, I think it's the eligibility and the presence of one or more chronic conditions or SMI. But, again, the issue was, you know, they were looking in their claims and saying, well, they had no therapy appointments this week, this month, they had no inpatient, they had no IOP, and, therefore, they don't get case management because they're getting services. Well, they might be referring them to God's Pantry, they might be referring them to housing, they might be referring them to shelters. So case management, in my definition, doesn't mean they have to have -- now, ideally, they should be trying to engage them in for that primary care, getting them to the services, but for some of our SMI folks that are paranoid and, you know, it's a very long process to build that kind of rapport in order to get them into services. We heard some denials based on MCOs looking at their

claims and saying, well, they have no other services, therefore, you're not taking issue to anything. We thought that was inappropriate based on the definition.

COMMISSIONER LEE: What information can we get to this TAC to kind of look and start evaluating how is targeted case management effective or is it being administered consistently across the state, across MCOs, across the state, across populations, and I think, you know, maybe not -- it's not something that we're going to have to define today, but I think something that we need to look at about what data that we had should we look at knowing that we have claims data for all these individuals. So what information do we need to be getting, and I see Sharley has her hand up, I think.

MS. HUGHES: There was a couple of comments in the chat. Marcy Timmerman has said that MHA of Kentucky -- sorry. Are there any quality measures for targeted case management that are nationally or internationally accepted? Is there a formal standard of practice for targeted case

management? And then Natalie says we have data on outcomes for homeless adults in Louisville, but that is a very specific population and includes a study by Passport or Well Spring clients. Let those two comments -- read those two comments in.

COMMISSIONER LEE: I think that's a good idea to see what national metrics are there, are other states using to pull in. And we could -- here at the department, we can poll our national association met directors, we can poll every one of them. And, Dr. Brenzel, I don't know if you all have access to your counterparts in other states to see if they're going along these lines. I guess, I think the overarching goal is to see, you know, is it effective, if it's not, what kind of other interventions do we need to be doing to make sure that individuals are receiving the care that they need to become the best -- to live their best life.

MR. KELLY: This is Mark Kelly for Pathways. One of the ways that we measure our targeted case management if it's

successful or not is the reflection of the 30-day re-admissions to the state hospital. That is something that we specifically look at across the board for all of our regions. So that could be something that you could look at as a decrease in the 30-day readmissions for folks that get targeted case management.

DR. SCHUSTER: Thank you, Mark. That's helpful. Natalie -- I assume that Natalie Harris talked about the data that you had with the Passport study as well as Well Spring. Can you forward that to me, please? I'll make sure that the DMS and DMA staff get that.

COMMISSIONER LEE: Yes. They're both research from family health centers and the -- I forget the name of the grant that Passport does to fund research. They --

MS. DOBBINS: IHOP grant.

COMMISSIONER LEE: IHOP grant. There you go. So Kathy's here. I'll get with Cary. And a lot of it is on cost where you can see the decrease in the cost to Medicaid and other resources providing the

case management.

DR. SCHUSTER: Very good. And, Kathy, you'll forward that to me, as well?

MS. DOBBINS: I sure will.

DR. SCHUSTER: I guess the other issue has been contact with the criminal justice system. I don't know, Commissioner Lee, you probably don't have any way of collecting that data. You know, I think our providers could possibly have that data. I wonder if that's -- if there's any way to get at that piece.

COMMISSIONER LEE: I can ask about that. I do know that we have -- I think the beginning of this month or next month, we're going to have access -- because, you know, we have to be able to identify an individual who is incarcerated because we cannot pay for claims for individuals that are incarcerated so there should be some way that we can get at that data with some sort of data sharing.

DR. SCHUSTER: I guess I would also be curious, I think it was Lori from Wellcare who said that their data shows or showed a trend that targeted case management was not

effective in reducing -- I think she said hospitalization, was a meeting in March. You know, let's see what that data looks like and maybe the other MCOs also have data.

COMMISSIONER LEE: I think it's important that when we look at hospitalizations we probably need to look at diagnosis because if somebody is admitted for appendicitis, then that's not exactly case management.

MR. SHANNON: Correct.

DR. SCHUSTER: Yeah, type of hospitalization and the diagnosis at the time.

MR. SHANNON: Some folks may need hospitalization despite good case management. Those things aren't mutually exclusive. I think your point about the appendix, that's not always true in ER data. There's appropriate and inappropriate use of ER. When my daughter was in -- four years old, she fell and broke her wrist. I didn't take her to the doctor for three days. That's probably inappropriate. She's fine, but I didn't do it. Right? But that wouldn't show

up on data anywhere. I think, you know, if you go to the ER, you know, the provider shouldn't be penalized for appropriate use of ER.

COMMISSIONER LEE: I think, too, talking about case management, I guess in my mind I keep looking at case management versus targeted case management to dig in a little bit more. I will send this. I've got the state plan amendment that was pulled out that outlines everything with targeted case management, and the regulations, of course, are on-line. I can recommend those. The information that I just shared, I'll send that out to this group, also, should you want to look at it.

I think going forward, we just, you know, again, I don't think we're going to do it in this meeting today, but just start thinking about what reports that we would like to see, what information can we look at to try of gauge the value of targeted case management and just kind of go from there.

MS. DOBBINS: I think we do have to come to some agreement about what are the

outcomes, what we want so see, and I think housing is certainly one of them. And I think, you know, looking at symptom reduction and reducing hospitalizations, I mean, I think there's a whole slew of outcomes that I think are part of recovery. But coming to an agreement about what those are, I think is our challenge.

MS. HUGHES: Could you identify yourself?

MS. DOBBINS: I'm sorry. My name is Kathy Dobbins, and I'm with Well Spring.

COMMISSIONER LEE: So I think Liz, there's a note in here that she would like see which provider is providing targeted case management, quality, TC... so she wants to see the providers who are delivering targeted case management. Pull that report in Medicaid if you want to see these providers. We can do provider name and number of individuals. We have to be a little bit careful when we start pulling dollars in. Some of that information is proprietary, but definitely pull providers who are delivering targeted case management and how many

individuals they have under age 18 years or over 18, or 21, whichever age group, under 18 and over, if you'd like to see that report in the next meeting.

DR. SCHUSTER: Yeah, I think it's really good, Commissioner, to have both the adult and the youth figures and subtract both of them because I think sometimes we get real focused on one and forget the other, particularly I think the kids. So really important. So can you send me the link to the reg, and I can get them out to the group, that would be great.

COMMISSIONER LEE: We'll try to get this report with just the -- the providers who are delivering and broken up by adult and youth, and we'll try to get that information to you before the next meeting so then everybody has it and can review before we meet and then we can talk about it at the meeting.

DR. SCHUSTER: That would be great. So does anybody else have any comment or question? I think the plan is that what we're hearing from the commissioner is that

there are not going to be a return to prior auths, at least until we have a much clearer picture of what targeted case management is supposed to do and is doing, which is, I think, very good news for us, Commissioner for that and thank Dr. Brenzel for weighing in on that. And I think we're all in this together as a team to try to be able to define: Let's talk about targeted case management as opposed to case management; let's talk about both adults and kids. Let's use under 18 because that's what your graphs refer to. And then let's share information we have, what data we have on, you know, what are the desired outcomes here so we can put our heads together and figure out, and you're going to be looking also, Commissioner, who the providers are who are doing targeted case management. And the goal would be we have another meeting on November 4th. Oh, the day after the election. You remember there is an election coming up. I don't know if that's the best day to be having a meeting. I think we ran into this once before.

Anyway, we will try to have that

information beforehand so people can look at that, and then we'll have, again, a very robust discussion.

Does that capture everything, Commissioner, as you see it?

COMMISSIONER LEE: It does.

DR. SCHUSTER: All right. Any other final questions on this topic before we move on? I'll ask the question of the voting members of the TAC, does this sound like a good plan to go forward? Val, you're very concerned and have been -- and we've got a thumbs up there. Sarah is nodding.

MS. KIDDER: Yes, absolutely.

DR. SCHUSTER: Gayle, this may evolve on the fee for service side. Certainly, your waiver folks, hopefully in the ADI waiver and so forth, but just in general does this sound like a good way to go?

MS. DICESARE: It does.

DR. SCHUSTER: And, Steve, from the CMHC perspective? Thumbs up. Okay. We have unanimity. Let's move on before anyone changes their mind.

The next item on the agenda is on the waiver for substance use disorder service to incarcerated persons. Is that you, Leslie?

MS. HOFFMAN: Yes. I was going to share my screen if that's a possibility, Sharley? Can you help with that?

DR. SCHUSTER: We want to hear about co-pay regulation, Commissioner. Sorry, Leslie. You can get ready.

COMMISSIONER LEE: Yesterday, the co-pay regulation review committee and it was -- it passed. We had some conversations with the members on the committee prior to that meeting because as you know the department's goal is to remove co-payments from the Medicaid population because of the confusion that surrounds co-payments. It's just administrative burden for the providers, not to mention they're creating a barrier to our members so our thought was to remove those. However, there was a question -- well, not a question. It was a statement that we did not have the authority to remove co-payments based on KRS 645 -- KRS 605.631(2) which states that the department shall collect

co-payments on certain -- they listed three topics.

So based on conversations with the committee and individuals that are also on the Medicaid advisory committee, we decided to amend our regulation to allow $1 co-payment for non-emergency use of the ER, pharmacy benefits and non-emergency ambulance transportation. But once that individual pays that first dollar co-payment, their obligation is met per year. We had to do that because of the statute.

What our goal would be actually would be to see if we could change KRS 205.6312 to state that the department "may" rather than "shall". That will prevent us from having to go through this exercise any time the wind changes. That would allow to -- I think it would be a win-win because the legislators would still have on the book the option to look at co-pays for Medicaid. I would really like to get that statute changed because in the past, co-payments have been waived from the budget bill and then they were recently waived in a couple of house bills, but those

bills expired in June of 2020. So that's why we were scrambling trying to get some sort of something on the -- in regulation saying that co-payments were waived. Now, however, co-payments are still currently waived and not in place throughout this state of that's where we stand right now. Hopefully, someone can take that pause in the future to change that statute.

DR. SCHUSTER: Well, we really appreciate the Department taking this up. I think the amount of time this TAC has spent railing against co-pays over the past four years for sure, and even before that, has been significant. I think if you go back in the annals of our minutes and the recommendations to the MAC, the issue of co-pays has come up numerous, numerous times because it's such a barrier. My suggestion was that we ought to be paying people with behavioral health issues if they do comply with their treatment and get the services that they need rather than charging them for getting those services. So we are delighted. I think you have come up with a very

innovative way to meet the statute and still get this done. Steve and I had an opportunity to reach out to members of the ARRS, Administrative Review Regular Subcommittee, there was not any feedback at all. So it still has to go, as you know, to the interim going through health and welfare and family services committee, but hopefully this is a win for everybody. It's a win for the providers. I assume it's a win for the MCOs.

COMMISSIONER LEE: The message, too, actually by having co-payments on the books right now, it's costing us about $16 million in federal funds.

DR. SCHUSTER: Wow. That alone would seem to be the significant argument.

MR. SHANNON: I'm not sure people got that yesterday at the administrative record. They understand that less federal dollars come from -- there's some confusion about that.

COMMISSIONER LEE: $20 million. Four of that is state funds and 16 in federal. So we're spending four million

dollars in state funds to get an additional 16.

MS. MUDD: So let me understand, the co-pay is a onetime --

DR. SCHUSTER: One time a year, Valerie.

MS. MUDD: So we're talking one dollar for the whole year.

DR. SCHUSTER: For the whole year.

MR. SHANNON: Pharmacy, transportation, use of --

MS. MUDD: For each service you're saying it's a dollar?

COMMISSIONER LEE: Once they pay that one dollar you're done with the co-pay obligation. So even if we have to leave this one on the books, it's not going to be a big game changer for Medicaid population. It's going to be a little bit of a headache administratively, but --

MS. MUDD: So when -- you said THEY are going to be waived through the pandemic?

COMMISSIONER LEE: Yes.

MS. MUDD: I mean, is this like we don't have any idea when that would actually

go back into effect?

COMMISSIONER LEE: We do not, and hopefully by the time -- you know, I would love for the pandemic to be over tomorrow. I don't see that happening. Hopefully by the time the pandemic... to complete co-pays from the Medicaid population.

MS. MUDD: I'd say it's safe to assume at least end of the year we'll be --

MS. HUGHES: Go ahead.

MR. BALDWIN: Bart Baldwin. I work on behalf of Kentucky Health Resource Alliance, ABA Advocates, and other provider types. I just wanted to say it is -- there was a good discussion in regards to the financial impact, and I think that's not been a piece that's been in the discussion in the past when we try to get bills passed to do away with co-pays. I think it's a really strong argument because the assumption is, you know, the commercial side of things, you collect co-pay that's a savings for the payer, but in the Medicaid fraud it doesn't work that way, like Commissioner Lee explained. Now, by adding co-pays are

actually costs for the state. Less dollars going to Medicaid for service. So I think that's a critical point, you know, when we get to the point of changing a statute to make that point because it really takes away the counterargument the co-pays, the whole scheme of the game discussion.

DR. SCHUSTER: Yes. It's a valid argument that we make and we should be making. I would hope that we could all get behind changing KRS 205.6312 and making that "shall" be a "may" and I think the fiscal argument would be the winner of that.

MR. BALDWIN: I would be okay "shall not."

DR. SCHUSTER: Yes, yes. Any other questions?

MS. HUGHES: Dr. Brenzel has his hand up.

DR. SCHUSTER: I'm sorry. Dr. Brenzel.

DR. BRENZEL: I'm sorry. I do not have a new comment. That must be old. I apologize.

DR. SCHUSTER: Sorry about that.

DR. BRENZEL: I support the commissioner's endeavors. We appreciate you taking it to the legislature, and we know that audience isn't always receptive, and we appreciate your perseverance.

COMMISSIONER LEE: So far they've been okay with me. They haven't given me as much grief as they have others.

DR. SCHUSTER: Let's keep it that way.

MS. HUGHES: Can you assign me back to host so I can admit people to the room and let Leslie share her screen?

COMMISSIONER LEE: Yes, ma'am.

MS. MUDD: I have a question real quick about the co-pay. Has a letter been sent out to members, I'm assuming, saying the change is with the co-pay?

COMMISSIONER LEE: I can always go back and double-check that. I do know that we alerted the providers. We'll go back and double-check.

MS. MUDD: Has there been a letter sent out saying that the changes, you know, after the pandemic?

COMMISSIONER LEE: No, we haven't for the one dollar one, yet, because we don't know how long the pandemic is going to go on, and we just don't want to create any confusion right now. So when we get ready to fully implement that regulation, if it still stays the same format, we'll send a letter out to members.

DR. SCHUSTER: There's another step, too, Val. It has to go to another committee and health and welfare, family services to be approved there, so that's another month and that would be premature, hopefully not eventually to let people know, but I think you all could spread the word that the news is good, no co-pays right now, no co-pays while we're in the pandemic and hopefully $1 a year, actually if they use pharmacy, ER, or transportation. So wonderful.

The next, Commissioner, was --

COMMISSIONER LEE: We've seen a lot of -- we've seen an uptake -- we have heard a lot of positive feedback related to the delivery of the telehealth services, so our

goal is to get a state plan amendment drafted to submit to CMS outlining some of the flexibilities related to telehealth that we want to keep so that we can keep that in place before the pandemic ends so that when we emerge from the emergencies that we'll be able to retain those flexibilities. And the same goes not only for telehealth but any sort of flexibility that we've put in place that we think has made it easier for individuals to access care, we want to maintain all the flexibilities we can, but telehealth is the main one. And again when we get that ready and we get to the point of going -- before we post it for public comments we will have a chance to comment on that before.

DR. SCHUSTER: Great. I know that Anna Whites is working with groups on mental health and substance abuse disorder and so forth.

COMMISSIONER LEE: We don't exactly have a timeline or anything like that, but that's definitely on our priority list. As soon as we get that, we'll let you all know.

DR. SCHUSTER: Wonderful. Thank you. Any questions for the commissioner on that? Again, I think a really positive step forward, particularly in the telehealth. I think I recorded in late June and I shared that PowerPoint with you all, you know, the uptick in telehealth has been amazing. Some of the CNHCs went from zero to, you know, 80% to 85% of their clients using telehealth. Now, there's been a lot of flexibility because you can use some other things that have typically not been HIPAA compliant. So I'm sure that's some of the things you're looking at, as well. It certainly has helped during the Covid, and it certainly helps people that have transportation issues. It also points out, unfortunately, how -- what do they call that -- deficits there are. I'm trying to think of the terminology that's being used now, the great divide between those who have broadband and those who don't.

COMMISSIONER LEE: We have heard it's cutting down dramatically on the number of no-shows for the office. I think that's definitely a plus.

DR. SCHUSTER: Yeah, we heard that -- I did kind of a really informal survey across, you know, using some of the provider groups, professional associations, and it was dramatic feedback from no-shows and same-day cancelations, you know, had gone down dramatically. People are able to use it from their home or office or wherever they are.

Any other comments or questions?

MS. EISNER: Nina Eisner, C.E.O. with The Ridge in Lexington, Kentucky.

One of the things that we talked about yesterday on the mental health telehealth work group the states put together is that we are using telehealth in very nontraditional ways, and we've been doing it for decades here at The Ridge. And individual therapy and psyche health and met management and all that sort of thing is very helpful, but when the pandemic hit, we had to also adapt partial programs and intensive outpatient program to this telehealth platform, and, again, we've done it for so long, we basically had to go buy Zoom licenses so that we could have more services available. It's

a lot harder for the therapists to conduct a THP on tele for example. For some populations, it doesn't work. Like children, we're often going to do one in person. But it is remarkable how it eliminated some of the geographic, geo-access issues related to being able to access certain level cares of hospitals, and the urgent response that hospitals can provide to each other in assessments and making sure that people get out of ERs, which is good for all of us. So I've always been a fan -- and we use Zoom, but the fact that it has worked so incredibly well with the levels of services well in terms of four, three and four hours per day of continuous intervention has been quite remarkable. So the extent to which the cabinet flexibility and our therapists being able to provide those services has been great.

The only question I have, Commissioner, is, you know, once we have a spot, will that override like the social work board, for example? I'm not sure that they -- about what their final deliberation about whether

or not non licensed clinicians, masters degreed clinicians get paid not to be under Medicaid changes and if we continue those sorts of things. I guess I just get stuck sometimes inbetween what is the board's authority versus the state's authority.

COMMISSIONER LEE: So our response would be the board's authority. The only way it would happen is if the board changed their rules. What our SPA would do would be allow us to have those flexibilities on such -- on platforms that were not necessarily approved for, but it would not override any board authority or allow individuals to bill for services if they cannot normally bill for those services under their licensure.

MS. EISNER: Thanks for clarifying.

DR. SCHUSTER: I would say at that same ARRS meeting, that the co-pay reg was approved, the license marriage and family therapist board changed their way, not letting their associate level which is -- folks that worked under supervision they had not been allowed to use telehealth.

MS. EISNER: Yes.

DR. SCHUSTER: It has to go through the process. I don't know that the social work board has, and I'm not familiar with the board about during, you know, really, days of Covid, but I think what the commissioner is saying is that the licensure boards have their own statutes and their own authority, and DMS is not in a position through SPA or anything else to do that. But the issue has been with those practitioners who work under supervision are allowed through --

MS. HUFFMAN: I'll say good afternoon. This is Florence Huffman. I'm the executive director -- social work. Glad to be here with you, and thank you so much. I'm sorry I didn't hear all the question about what the board had determined to do. I will just re-explain that under the governor's social distancing, the board did issue several different memos and one of them is that a CSW masters category license under supervision would be considered a treating clinical social worker and be allowed to provide telehealth. We had a meeting yesterday, and although nothing is firm, the

board chairman and board maybe indicated that they will be considering very seriously the emergency kind of rulings and which one of those should be turned into a permanent order. And I believe the CSWs under supervision will be permitted to continue to provide telehealth, and that was also viewed as a really unethical decision on the part of the board.

Now, the one thing they haven't relinquished is their authority to not allow someone who holds a temporary permit to provide any telehealth services. So that's the update that I bring on behalf of the board. And I'm pleased to be part of this discussion.

DR. SCHUSTER: Thank you so much, Florence, and thanks for joining us. That's really helpful. I think there is a lot of questions... consider that at their next meeting and that the board has allowed that during the period... and again MFT board just changed their reg. Ann? You're muted.

MS. HOLLEN: This is Ann Hollen, behavioral health policy advisor of Medicaid.

I do want to say that clinical supervision is different than billing supervision. So if you have a CSW that is under clinical supervision for their LCSW and is working for you, then they can do the telehealth, but if you have a masters level CSW not under clinical supervision they should be doing telehealth and bill them for it. You have to make sure it's both because billing is completely different than clinical supervision. I just wanted to point that out.

DR. SCHUSTER: Thank you, Ann. I think the concern, Ann, that I've heard is people from agencies that raise this, in this case is CSWs. I think it was also the MFT associates were afraid of getting in trouble with their licensure board. So, you know, I think the clarification from the board is helpful in that regard. And then you're right, the billings is a whole different kettle of fish or can of worms. Thank you so much, Florence. That's really, really helpful to have you on.

MS. EISNER: Just so I can clarify,

Ann, what we're talking about is exactly what you and Florence are talking about, individuals with the CSW who are under formal clinical supervision. Same for LMTT. So thank you. I agree.

DR. SCHUSTER: Yeah. That's very helpful, and that, in theory, is the workforce, actually, and, you know, they hold a license while they're under supervision so they are subject to follow the laws under that licensure board. Thank you.

Leslie, I think we actually are going to you now.

MS. HOFFMAN: Looking. I still think I cannot share, yet.

MR. BALDWIN: Sheila, while we're doing that, I have one final comment for folks and Commissioner Lee. In terms of telehealth is, and as far as payment parity, to be sure that the service that's provided in person and the service that's provided by telehealth has payment parity. So one of the things that we've seen all these benefits and seeing access for services for telehealth would quickly go away if all of a sudden

they're not paid at a same level, fifty percent less or twenty percent less, or something like that. It would be much more difficult to maintain those services. So I just wanted -- that's really an important piece.

COMMISSIONER LEE: I don't see that changing as we go forward.

MR. BALDWIN: Okay. And, again, I just wanted to be sure that's something that stays in place. Thank you.

DR. SCHUSTER: Thank you. All right. Leslie, this is your baby.

MS. HUFFMAN: Can everybody see my screen? Okay. I'll share this later with you, Sheila, but I will try to summarize this. I know several folks on the call have probably seen this similar demonstration already at the other task force. So I'll just go through it.

So House Bill 352 basically said that the Department of Medicaid along with the Department of Corrections is working in corroboration and together to draft and submit an 1115 demonstration waiver, and this

would be to give incarcerated members substance use disorder treatment while they're behind the walls, and it's something that hasn't been done before. In the red there, you'll see that currently that CMS does not allow for state Medicaid agencies to pay for those services except just they have to leave for 24 hours maybe to a hospital or something like that.

I gave some very basic information here, but the main keywords that I pull out of these bullets is to remember an 1115 waiver is a pilot or demonstration. And when we say demonstration that means it can continue if we request it to. This is our time to demonstrate that we can do this better and that we can help these clients more and have a better quality of life and that we can provide these services equal to or less -- there's our favorite word, budget neutrality. We have to make sure that we can provide it equal to or less than what we currently spend on the members, and we've been working very diligently for weeks trying to figure out how to make that comparison since we don't cover

substance abuse services behind the walls right now.

The 1115 also gives us the ability to go beyond just the regular routine medical care. So this has been a very exciting adventure.

Right now in Kentucky, after the house bill --

MS. HUGHES: Leslie? I'm sorry. Since you're the host, go at the top of the participant list. There's some folks trying to get admitted.

MS. HOFFMAN: I see them.

MS. HUGHES: Can you admit them, please?

MS. HOFFMAN: Kentucky's initiative right now is that Kentucky is requesting CMS to approve an 1115, and we're making this an amendment to our existing SUD 1115 for substance abuse treatment to eligible incarcerated individuals and to cover these services. So this, again, this is very exciting.

We have a two-prong objective in our amendment, and that is to provide these services while they're incarcerated so that

they receive those services prior to release and then that we will strengthen their followup care with their Medicaid provider and to make sure that they've got those services while in.

We're also trying to -- we want to be able the last 30 days before their release we want to -- the recipients chose an MCO to coordinate some of the aftercare, and we've also been talking about, maybe, some type of housing. Not housing like service housing, but like housing assistance, and that may just be some care coordination.

So if this is approved, Kentucky will be the first state in the nation to request this type of SUD incarceration amendment, and like I said it's very exciting. One of the things that we're running up against on timeline is that CMS is working on their own policies. They don't have their own policy procedures, best practice, their state Medicaid director letters, those haven't been developed, yet. They're still working with their stakeholders. So they've been kind of working with us along the way, and we're kind

of, for lack of better words, their guinea pig. We've been working with them on what this is going to look like, and then they will develop their own policies and procedures. So we have had initiatives in the past where we've been ahead of what CMS is doing, and that does make a delay, but there's no delay that we're trying to cause or not to address.

I see somebody's -- Val, did you have your hand up?

MS. MUDD: You said for those who qualify. Would there be ways that folks, you know, that need substance abuse treatment, would there be reasons they wouldn't qualify?

MS. HOFFMAN: So currently right now the Department of Corrections have several different programs that they're providing right now. They have a SAP and SOAR. I would tell you, and I'll find out a little bit more, I will tell you that we are looking at defining "incarcerated" as day 1 which would catch the pretrial folks that get stuck in the system, so that's something that's very positive. And also there's --

SAP and SOAR are their substance abuse treatment modules that have the whole assessments and modules that they go through for six months, and then the SOAR is the aftercare that they continue until -- they are released after they complete SAP. Ann, if you're on and I've said anything that helps or if I didn't include anything, feel free to jump in.

So anyway, I think I -- sorry. Did somebody have a question?

MS. HOLLEN: I think you're doing okay. How they would be eligible is based on assessment that the Department for Corrections does on this. They have to be eligible for their substance abuse program, and then, also, SOAR is their recovery program. So that's the main qualification. So you have to have a charge related to -- there's a statute. I think it's -- I'm going to get it wrong. 216, maybe, and then you have to have an SUD diagnosis as well. So 230, there it is. 218.

MS. HOFFMAN: Primary diagnosis or not. Yeah, I do think it has to be to get

into the program. CMS asked for another graph before we send it out for public comment. So that was moved. The public comment was actually something extra that CMS asked us to do that we weren't told that we had to do for the first couple of calls, so that delayed just a tad. So these are the top things we're looking at. Remember that everything is pending CMS approval, and this date here where CMS has requested additional drafts, that's been getting back to us with any comments, usually in about ten to 14 days, so I just estimated that. I will tell you on our last call with them they only had two comments and they were not bad comments and we had already addressed one. So I'm not feeling like they'll have an extensive amount of comments for us during that time. It will go out to public comment when we go through the whole transparency speech that we do with any other waiver or waiver amendment. That will go out for public comment. We're hoping to have it out by 9/30 timeframe to CMS back to CMS for approval would be 10/30 in October. But now again, I really feel like

we may have some delay when it gets to CMS, like I said, because they're still working with their stakeholders. So and Dr. Brenzel is on our team. We've had such a -- and Dr. Marx. We've had such a wonderful group of people to work together. We've had Department of Behavioral Health, and Office of Inspector General, Department of Corrections, a really hardworking group, and I can't say enough about the team and how they get things together at the spur of the moment. I've just been very appreciative because we've been on a timeframe since this came out through House Bill 352. So, Dr. Brenzel, if you want to say anything, you can, too.

DR. BRENZEL: No. I just think this is an example of an opportunity for Kentucky to lead and could really improve the transition from incarceration to the community by ensuring that there's handoffs and that appropriate Medicaid eligibility is in place, that a managed care company is selected, the pre-authorizations are done. So very excited about this.

DR. SCHUSTER: Leslie, this is Sheila Schuster. I think you had explained in a different call I was on with you that this waiver covers only the substance use disorder treatment and aftercare, but if they have a cooccurring disorder that's mental health, that that's taken care of by Department of Corrections personnel. Right?

MS. HOFFMAN: Yes, when they make the assessment, that's correct.

DR. SCHUSTER: Thank you. Because I think maybe Val had a -- you know, was kind of referring to the cooccurring --

MS. HOFFMAN: Okay.

DR. SCHUSTER: Because we know so many of our people have both.

Does anybody have any questions for Leslie? I know that she and Ann and other, Dr. Brenzel, Dr. Marx over at DBA have really put in a ton of work on this as well as your counterparts over at the Department of Corrections. So this is really exciting. I wish that the next budget bill would include language like this for an SMI waiver, which we've only been asking for for 15 years, so

maybe we can get somebody on the budget and get it done.

Any questions for -- yes, Marcy? Oh, you're clapping. Marcy is giving you a clap, Leslie.

MS. HOFFMAN: We are very excited about this. Ann and I talked about this probably six or seven years ago. So we've been very happy with the work so far, and especially if we get it approved. We will feel like we've done some big work in Kentucky. Yeah, very exciting. Should be able to share screen with somebody else, Sharley.

MS. HUGHES: Still shows you as host. Sheila, there are several that are asking if they can get copies of the presentation. I think you normally send everything out to --

DR. SCHUSTER: I do, and I was going to make this announcement. If you get my regular e-mails about the TAC, then I have you in my computer, my wonderful computer, with a long, long list. If you don't, if you got this from somebody else, if you will send

me an e-mail saying I was at the TAC, I want to be on for the materials, and Marcy maybe you can type it into the chat. It's hard for me to do that while I'm hosting. It's KYADVOCACY@GMAIL.COM. So, again, if you're not sure you're on my list, send me an e-mail and just say I want to be sure to get on your list. And I will send out the various PowerPoints that we had today and then also the information on targeted case management and the links to the regs. And then several people on the call, Kathy and Natalie, for sure were going to send me some information for some the other way. So that would be great.

Any other questions?

So the next item is implementation and timeline, and I have the wrong number, but the issue is single Medicaid formulary, and I assume that, Commissioner Lee, that goes back to you?

COMMISSIONER LEE: So we currently have an RPF on the street for a single PDM, so I can't talk much about Senate Bill 50. I can give you the activity, though, is that we

released that RFP on August 14th. The first set of questions were received August 25th. We responded to those questions on September the 1st. And now there's a second set that was due September 8, which was yesterday. I'm shot sure if we received questions. And so the proposals will be due by October 6th. The single -- so there's two, I think, topics. There's a single PDM, and there's a single preferred -- so I believe, and I will double check, but I believe that we will have a single preferred drug list in effect January 1st of 2021, but the single PDM, a contract will be signed by January 1st of 2021, but it will take us some time to implement that single PDM. But I do believe the single PDL, the preferred drug list, will be in place January 1st 2021.

DR. SCHUSTER: Commissioner, for those who are on the call that may not be familiar with PBM, the pharmacy benefit manager, can you give a very short definition of what that role is? That would be helpful.

COMMISSIONER LEE: Sure. So currently all MCOs have their own formulary,

drug formulary, and they also have -- they contract with pharmacy benefit managers, or PBMs. They administer their pharmacy benefits for them, and Senate Bill 50 required the Department to secure a single pharmacy benefit manager for all MCOs to use. So we have an RFP on the street right now to secure a single pharmacy benefit manager for all MCOs to use, and that contract -- we anticipate that contract being effective January 1st, 2021.

And the single PDL, preferred drug list, believe we have plans to have a single preferred drug list which is a drug list that all MCOs and the Department will use by January 1st of 2021.

DR. SCHUSTER: And what's the process for coming up with that single PDL?

COMMISSIONER LEE: I do not know. Maybe Dr. Jessin Joseph could join us on the next TAC meeting, if you wanted more information on that.

DR. SCHUSTER: That would be great. I've been in meetings with him and he really does a great job of explaining everything.

For those of you who -- here's the layman's view of a PDL, and that is that if you want to prescribe a drug and it's on the PDL, then there's no prior authorization, no hassle, no whatever because everyone has agreed that that's a drug of choice. That's basically what a PDL is. So if you have something on a same class, an atypical and/or psychotic and it's not on the PDL, it doesn't mean that it's perhaps not available, but you will have to go through some hoops.

Is that a pretty accurate description?

COMMISSIONER LEE: Sounds like a pretty accurate description.

DR. SCHUSTER: For those of you who are new to the call or haven't been in our BH TAC meetings in the past, right up there with co-pays we have probably had more discussion and more recommendations about returning to what we call the single Medicaid formulary. So before we had MCOs, Medicaid had a formulary, and it had a pharmacy and therapeutics committee, a P&T committee we call that. They actually did legislation with Senator Julie Denton -- that's how long

ago it's been -- to add a second psychiatrist to that P&T committee because we really worked hard to provide testimony to the members of the P&T committee about various medications that we felt like our folks needed to have access to. When the MCOs came in and each of them, as the Commissioner said, had their each formulary with their own PDL and their own P&T committee, which were not very accessible to applicants, we really felt like we lost that opportunity for advocacy and input, and it was very confusing to describe. Because you would have a client, you would have a diagnosis, you would know their history with medication, and then, you know, there was no way you could keep in your head which MCOs were covering which drugs as their PDLs and so forth. So it was just a nightmare. So I'm thrilled at this meeting we're talking about actually seeing two of our dreams come true, and we are looking forward to that come to fruition relatively soon. So we think it's going to be easier for folks to understand and certainly easier for prescribers because you

all know there's such a shortage of -- that we really need to have them seeing patients and prescribing and not doing the paperwork that goes with prior authorizations.

At our next meeting, can you make that invitation for us, Commissioner Lee, or I can e-mail you and get his email address? November 4.

MR. BALDWIN: So I know the dreams, one of the things just to be sure we're still on pace for the single credentialing agency, I know that was something that was a bill passed a few years ago that was -- on pace with 1/1/21 as well?

COMMISSIONER LEE: We did prepare an RFP and award was made, and it is under protest right now, so I'm not sure if we can talk about that.

MR. BALDWIN: Sure. Okay. Thank you.

DR. SCHUSTER: So maybe we can put that on the next meeting agenda and maybe there's some resolution to the protest by that time because Nina Eisner and others have really pushed for that single credentialing

agency. What that would mean, folks, is that if you want to get credentialed for Medicaid and an MCO, a single agency to help do that should streamline the process and shorten the process for providers. Good question, Bart. Thank you.

Any other questions? All right. Commissioner, we're talking about an MCO update, legal challenges. I know Anthem had one and I think maybe it's been resolved. Open enrollment dates and the mechanism for assigning recipients to the new MCOs.

COMMISSIONER LEE: We have Angie Parker on the call with us today. Angie is the division director of Program Quality and Outcomes and oversees the managed care contract organization. Angie, would you like to speak to this topic today?

MS. PARKER: Sure. We are working on, obviously, the managed care readiness, and we plan on being ready 1/1/21, and the open enrollment starts November 2nd and ends December 15th. We plan on getting some open enrollment information out. It will probably be the end of this week or the first of next

week, and we are just moving right along, meeting after meeting, trying to make sure that everything is set up and ready for 1/1. Do you have any particular questions that you would like for me to answer?

DR. SCHUSTER: I think we're all curious about the Passport Molina. So people that -- everyone who's a current recipient would have an opportunity during open enrollment to choose any of the five current MCOs. That would include Passport/Molina?

MS. PARKER: Yes. Passport by Molina Healthcare.

DR. SCHUSTER: And that would still include Anthem?

MS. PARKER: No. Anthem is not one of the managed care companies that are effective 1/1/21. So Anthem would have membership until the end of 2020.

DR. SCHUSTER: So would it include United Healthcare?

MS. PARKER: Yes. Thank you. The five managed care companies are United Healthcare, Passport Health Plan by Molina Healthcare; Aetna; Better Health of Kentucky;

Humana; and Wellcare. I should have done that alphabetically. I would have done a better job.

DR. SCHUSTER: So that helps. So United, along with Molina, are the two coming in new.

MS. PARKER: Yes, ma'am.

DR. SCHUSTER: So they will be listed as choices.

MS. PARKER: Yes, ma'am.

DR. SCHUSTER: During open enrollment. When you send out and when Medicaid sends out announcements and so forth, we certainly stand ready. All of us on this call represent various parts of Medicaid advocacy, family members, providers. We would certainly like to be part of distributing any information that you have. If you're sending flyers out, if you're sending letters, which would be helpful for us to maybe get a copy so that we could be sure that people know what they're getting in the mail.

MS. PARKER: I can certainly show you what will be sent, yes, ma'am. I don't

know that they all -- we sent them out to the printers so I can verify everything and see what I can share at this time.

DR. SCHUSTER: Yeah, and I don't want you to share anything you're not ready to, but we're anxious to be of help to you and make sure the people understand and understand the choices will be different. Right?

MS. PARKER: Yes, ma'am.

DR. SCHUSTER: That would be great.

MS. EISNER: Angie, what if enrollees don't select an organization, a different MCO? Do they stay with Passport? I guess same question would apply to any of them. Enrollees will stay in their own plan unless they select another one?

MS. PARKER: That is correct.

MS. EISNER: And true for Passport, as well, even though old Passport's not there anymore? They will stay with Passport?

MS. PARKER: Yes, ma'am.

MS. EISNER: Unless they choose something else?

MS. PARKER: Yes, ma'am. That's

correct.

COMMISSIONER LEE: Do you have an MCO contact, I can pull the piece out and send to you about how actual assignments will work going forward, and the other piece to this is that all children in foster care will be in one MCO now. That is Aetna. They have the SKY contract so all the children will be enrolled.

MS. PARKER: Thank you, Commissioner, for bringing that up, yes.

DR. SCHUSTER: I had forgotten about that. That's a whole separate program so to speak. So that's an automatic assignment.

MS. PARKER: Yes, ma'am.

DR. SCHUSTER: Foster care kids to Aetna SKY program.

MS. PARKER: Yes, ma'am. If there are any foster aged children in any of the other managed care companies, they will be transferred or assigned to Aetna Better Health.

DR. SCHUSTER: Okay.

COMMISSIONER LEE: Again, Molina

has bought Passport so that deal was effective September 1st of this year, so they actually bought Passport and their members. So they will be staying with -- if they do not choose another MCO, they will mostly stay with Passport, but we do have in the contract with the MCOs specifically how members will be assigned so I can send that out to the group so you can look at that.

DR. SCHUSTER: That would be wonderful. Thank you very much. Bart?

MR. BALDWIN: Also, just another comment on Kentucky SKY. Kelly Pullet, they've hired her as the statewide director as Kentucky SKY. You may remember Kelly from Anthem. She has been at the behavioral health TAC a number of times. So just wanted to let the group know that that's up and running. They've already hired her. She's full-time. We've had some meetings with providers with her. Just to let you know, that system, they're already in gear on that and have folks on board and somebody comes from the provider community in Kentucky, so I think that's helpful.

MS. PARKER: Yes, there's been a lot of meetings, also, regarding SKY and getting that role in there as Bart mentioned. So it's all rolling along.

DR. SCHUSTER: And you've been a little bit busy, Angie, I assume.

MS. PARKER: Yes, ma'am, just a little bit.

DR. SCHUSTER: That really answers the questions I had. Does anybody else have any other questions or comments about MCOs or open enrollment?

MS. MUDD: The folks that I work with are sometimes afraid to open their mouth, you know, because there might be something deadly in it. If they're using one of the old MCOs that are not renewed January 1, what happens if they don't choose an MCO?

COMMISSIONER LEE: They're currently assigned to, let's say, for example, they are assigned to Anthem and they do not choose a new MCO, they will be reassigned based on the algorithm. They will be assigned and then they will receive

information from the MCO. And, again, for those people who are automatically assigned because they don't select a new MCO, if the MCO is not there anymore, for those individuals, they will have a 90-day period which they can select an MCO.

MS. PARKER: I'll let you know that also the open enrollment material will be on the website, as well, so that will be out there to help.

DR. SCHUSTER: There will be letters sent out as there always is, Angie, to the individual members, but you will also have a link. I know you have computer -- assuming people that could get participation station at some of the places that need that, having that link on the website may be helpful, as well.

MS. PARKER: Yeah, it will be there. And our DCBS partners obviously will be assisting us in this, as well.

MS. HUGHES: I'll be e-mailing the material out to all the TAC members and the MAC, also.

DR. SCHUSTER: Great, Sharley.

Thank you. Any other questions on that? Then we will move to -- and this is kind of a leftover item. I don't know that it's changed from the last meeting, Commissioner, the status of the 1915(c) waiver redesign. Paused, I think.

COMMISSIONER LEE: It's still on pause. The last thing we want to do during a pandemic is disrupt anyone's care. And as you know, there was a big effort underway with 1915... there was a report from -- generated with some recommendations, and we have been reviewing that report and looking at the recommendations, and we believe there are some good recommendations that we may need to follow up with and revisit that report and go through it. But we did -- this is a redesign that was started in the previous administration, but, you know, if it's -- if there's value in it, we want to look at it, and we want to implement.

We were approached by some providers with some concerns about some of the changes that were recommended, particularly around reimbursement because in order for us to do

this, we have to -- some of the changes -- some of the changes with reimbursement would have to be budget neutral because we don't have -- so there was some shifting of funds or rates. You know, for example I think the ABI waiver had -- you could see a decrease in reimbursement and some other waivers would see a slight increase. So we, again, we think the report is very valuable. We want to get to a point where we revisit it and make these things beneficial to the populations.

DR. SCHUSTER: Thank you very much. And you mentioned the ABI. I think Diane is on -- been working on a work group on some ABI waiver regulations? Are you with us, Diane? Diane Schirmer? I know that Mary Haus was going to be on but had an appointment she had to keep.

MS. HUGHES: I don't see Diane in the participant list, but some people that have called in so it's only showing a phone number.

DR. SCHUSTER: Let me move on and then if she's here, we'll figure out -- maybe

she can figure out how to get to us.

What about any recommendations to the MAC? The MAC is meeting for the first time since January because their March meeting was canceled and then every meeting since then. So they are meeting on September the 24th, 10 to 12, or 10 to 12:30 via Zoom. Do we have any recommendations?

I would suggest that we thank DMS for their work on the co-pay regulation and make a recommendation that as soon as that regulation is in effect and at the appropriate time that they notify recipients of the changes. Obviously, the timing needs to be somewhere close to where we think the hearing of the emergency is ending, but we make that recommendation about notifying members of the change and the co-pay requirements. That's my motion. Is there a second from one of the TAC members?

MR. SHANNON: I'll second that. Steve Shannon.

DR. SCHUSTER: Any discussion? Val, does that make sense to you? I know you raised that point. All right. A vote by the

voting members of the TAC on that recommendation, all in favor signify by saying aye. And opposed? And abstaining? Answers unanimously.

Any other recommendations?

Nina?

MS. EISNER: I was just going to let you all know that it's been my pleasure to accept the commission as hospital representative to the MAC.

DR. SCHUSTER: Oh, wonderful. Chris has been a force on there, and I know you will be, also, Nina. That's wonderful to have a behavioral health person on there. I think we need to change the makeup of the MAC actually to have a behavioral health representative. You know, it took us a long time to get a behavioral health TAC. I think we've proven our worth. I think we ought to amend it -- congratulations.

MS. EISNER: Although, to be clear, I'm responsible for representing all hospitals.

DR. SCHUSTER: We know that. We know where your heart is, too.

MS. EISNER: That's true.

DR. SCHUSTER: Wonderful. Any other recommendations for the MAC?

All right. I have recommended agenda items for our November meeting, and we mentioned several, actually. One was to hear from the DMS pharmacy director about how the PDL will come into existence, and follow up on the single credentialing agency. So those two, several of these will have followups, I think, as well.

Is there anything that anybody had a burning desire to discuss that we didn't get to it today but we can put it on the next agenda for the next meeting?

MS. MUDD: I have a question, I guess. I'm not sure if I know how to word it. With the PDL, with it being all the same, in the past when each MCO had their own PDL, there were changes like constantly. Remember? If they have one, will that increase the -- does that make sense? Will it increase the amount of changes because all the MCOs are going to say, I want to change this, this, this, and this. Does that make

sense?

DR. SCHUSTER: It does.

MS. MUDD: It feels like to me it could go either way, you know.

DR. SCHUSTER: Well, what I'm trying to remember is whether Medicaid makes changes to their formulary and to the PDL that don't go through the P&T committee. Isn't that kind of the mechanism, Commissioner?

COMMISSIONER LEE: Yes. I believe all the changes to the PDL through the P&T committee and Dr. Joseph could specifically speak to that at the next MAC. And I believe that Dr. Carrio (phonetic) has informed me that I believe that we're going to use the fee for service physician drug list and enroll the MCOs into that drug list, PDL.

DR. SCHUSTER: Okay. So my understanding, then, Val, is that we have more analysis in this system with a single formulary single PDL so that we can work with the P&T committee. I think we were -- you're probably remembering a very contentious meeting we had at the BH TAC when one of the

MCOs just completely blindsided us and took some very frequently prescribed drugs off the PDL without any justification.

MS. MUDD: That's what I was thinking of. I was like, okay, you know, is there going to be a crap load of changes, you know? It could go either way.

DR. SCHUSTER: I think it's going the other way that it's really much more of a public mechanism because those committees, those schedules are there and so forth. So it's an excellent question, and I think if -- if Dr. Joseph, Jessin Joseph can address that, as well, at the next meeting?

COMMISSIONER LEE: He'll be able to address that at the next meeting.

DR. SCHUSTER: Wonderful. Thank you.

MS. EISNER: Sheila, may I put something else on for the next agenda item? We were talking about centralized credentialing which came out of House Bill 69 a couple of sessions ago. Centralized credentialing or the House Bill 69 was a single medical necessity criteria for use

across all MCOs. And, you know, there was an effort to advance InterQual, but then, Milliman, you know, there ended up being that suit, and that kind of stopped that. I don't know with the new MCOs if the Cabinet could just come back next time and let us know kind of where that whole centralized, similar --

MS. PARKER: I can speak to that, briefly. I can tell you that it's still -- InterQual and/or Milliman, they have to use those first because of that, and those requirements are still the same. So that aspect hasn't changed and there is additional criteria that did not address in InterQual or Milliman. They are to get the Department's approval.

MS. EISNER: Thanks for clarifying.

MS. PARKER: Yes, ma'am.

DR. SCHUSTER: Does that clarify your question?

MS. EISNER: It does.

DR. SCHUSTER: Because of the lawsuit, there's no way to get it down to a single one? Is that the upshot of the lawsuit, I guess? I'm not familiar with the

lawsuit in great detail.

MS. EISNER: Isn't that it, Angie?

MS. PARKER: Yes, ma'am, that's my understanding.

DR. SCHUSTER: Okay. Well, maybe we need to have a lawsuit on the other side.

Next MAC meeting, again, is on the 24th, and I'll be sure that you all have -- Sharley, you'll be sending out the Zoom link for the MAC meeting?

MS. HUGHES: Yeah. I think it's already on the website. I'm pretty sure I already sent that. The agenda will be added -- within a week prior to the meeting, the agenda will be added. But I'm pretty sure -- yes, the link and so forth for the meeting is already out there.

DR. SCHUSTER: Thank you.

MS. MUDD: 10 to noon?

MS. HUGHES: 10 to 12:30.

DR. SCHUSTER: 10 to 12:30.

MS. HUGHES: It used to be 10 to noon, but they got a little windy.

DR. SCHUSTER: I won't make any comment about the newest MAC member adding or

subtracting to that. How's that? We're delighted you're on. And then our next BH TAC, and we really want to concentrate on the targeted case management data at that meeting. So, you know, you all have my e-mail address. If you're aware of studies that are out there, if you're aware of national organizations -- Steve, I don't know what the national council might have or the CHCC group might have in terms of some of those measures effectiveness that we might look at --

MR. SHANNON: I'll try to find out.

DR. SCHUSTER: This is the time, I think, to really reach out to our national groups to see what criteria is out there and let's put our heads together. This a service that we want. We have it available now because there's no prior authorization. Thank you, Medicaid and DBH. So let's make good use of it.

If there are no further questions or comments, I'll pause here for a minute. We are actually ending a few minutes early. I think it was a very productive meeting and I

appreciate -- how many folks did we have?

MS. HUGHES: There are 62 currently in the meeting.

DR. SCHUSTER: How about that? You know, goes along with my axiom that there's no tent big enough to put everybody under so there you go.

MS. HUGHES: This is true to why with social distancing we have to do these especially this one via Zoom because we don't have rooms big enough in Frankfort big enough to social distance all of you.

DR. SCHUSTER: Yeah, yeah, that's right. So I hope all of you will stay safe and healthy. Again, my e-mail address, KYADVOCACY@GMAIL.COM. Get on our list and we're happy to share all this information with you, and I cannot thank my TAC members enough and certainly, Commissioner, all of you and all of your staff, and Dr. Brenzel, thank you so much. It just makes all the difference to have you all here and providing that information. And we're excited, Leslie, about the SUD waiver. I'm going to start working on getting one for the SMI in the

next budget bill. Get ready for that one.

Thank you all, and we'll sign off at this point. I appreciate you all.

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MEETING CONCLUDED AT 2:53 P.M.

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REPORTER'S CERTIFICATE

STATE OF KENTUCKY)

COUNTY OF FRANKLIN)

I, Kathryn Marshall, Court Reporter, and Notary Public in and for the Commonwealth of Kentucky at Large, do hereby certify that the facts as stated by me in the caption hereto are true; that the foregoing answers in response to the questions as indicated were made before me by the witness hereinbefore named, after said witness had first been duly placed under oath, and were thereafter reduced to computer-aided transcription by me and under my supervision; and that the same is a true and accurate transcript of the proceedings to the best of my ability.

IN WITNESS WHEREOF, I have affixed my signature and seal this 22nd day of September, 2020.

_____

Kathryn Marshall, Court Reporter
Notary Public, State-at-Large
Notary ID 608218

My Commission Expires: August 4, 2023